FOR OHF USE

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2005
STATE OF ILLINOIS
DEPARTMENT OF HEALTHCARE AND FAMILY SERVICES
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2005)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. **IDPH Facility ID Number:** 0021428

Facility Name: Walker Nursing Home

Address: 530 East Beardstown Street (Number) Virginia (City) 62691 (Zip Code)

County: Cass

Telephone Number: (217) 452-3218 **Fax #** (217) 452-7746

IDPA ID Number: 37-0960906

Date of Initial License for Current Owners: 01/01/1955

Type of Ownership:

	VOLUNTARY,NON-PROFIT	X	PROPRIETARY		GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code			Corporation		Other
		X	"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact
Name: Becky Hill **Telephone Number:** (217) 789-7700
Please send copies of desk review and audit adjustments to address on this page

II. **CERTIFICATION BY AUTHORIZED FACILITY OFFICER**

I have examined the contents of the accompanying report to the State of Illinois, for the period from 10/01/04 to 09/30/05 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) George W. White or Mary Ann Whit

(Title) Co-Administrators

Paid Preparer

(Signed) SEE ACCOUNTANTS' COMPILATION REPORT (Date)

(Print Name and Title)

(Firm Name & Address) McGladrey & Pullen, LLP P.O. Box 159 15 S. Old State Cap. Plaza, Suite 200

(Telephone) (217) 789-7700 Fax # (217) 753-1654

MAIL TO: BUREAU OF HEALTH FINANCE
ILLINOIS DEPT OF HEALTHCARE AND FAMILY SERVICES
201 S. Grand Avenue East
Springfield, IL 62763-0001 **Phone # (217) 782-1630**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/04 Ending: 09/30/05

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	71	Skilled (SNF)	71	25,915	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	71	TOTALS	71	25,915	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Medicaid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	365	896		1,261	8
9	SNF/PED					9
10	ICF	9,648	7,121		16,769	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	10,013	8,017		18,030	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 69.57%

D. How many bed-hold days during this year were paid by the Department?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ] Non-allowable costs have been eliminated in Schedule V, Column 7.

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location
Date started 01/01/1955

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date N/A NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [ ] NO [X] If YES, enter number of beds certified _____ and days of care provided N/A

Medicare Intermediary N/A

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year YES [X] NO [ ]

Tax Year: 09/30/05 Fiscal Year: 09/30/05

* All facilities other than governmental must report on the accrual basi

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home # 0021428 **Report Period Beginning:** 10/01/04 **Ending:** 09/30/05

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger Salary/Wage 1	Supplies 2	Other 3	Total 4	Reclass-ification 5	Reclassified Total 6	Adjust-ments 7**	Adjusted Total 8	FOR OHF USE ONLY 9	10	
	A. General Services											
1	Dietary	107,000	1,745	5,376	114,121		114,121		114,121			1
2	Food Purchase		123,119		123,119		123,119	(414)	122,705			2
3	Housekeeping	46,437	10,534		56,971		56,971		56,971			3
4	Laundry	25,474	41	1,317	26,832		26,832		26,832			4
5	Heat and Other Utilities			62,786	62,786		62,786		62,786			5
6	Maintenance	31,602	9,806	38,407	79,815		79,815		79,815			6
7	Other (specify):*											7
8	**TOTAL General Services**	210,513	145,245	107,886	463,644		463,644	(414)	463,230			8
	B. Health Care and Programs											
9	Medical Director			2,000	2,000		2,000		2,000			9
10	Nursing and Medical Records	664,925	41,928	14,183	721,036		721,036		721,036			10
10a	Therapy			1,300	1,300		1,300		1,300			10a
11	Activities	20,607	4,512		25,119		25,119		25,119			11
12	Social Services	22,080		5,100	27,180		27,180		27,180			12
13	CNA Training											13
14	Program Transportation			1,378	1,378		1,378		1,378			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	707,612	46,440	23,961	778,013		778,013		778,013			16
	C. General Administration											
17	Administrative	92,340			92,340		92,340		92,340			17
18	Directors Fees											18
19	Professional Services			34,946	34,946		34,946		34,946			19
20	Dues, Fees, Subscriptions & Promotion			7,757	7,757		7,757		7,757			20
21	Clerical & General Office Expense	39,360	29,033	8,739	77,132		77,132	(713)	76,419			21
22	Employee Benefits & Payroll Taxe			188,612	188,612		188,612	414	189,026			22
23	Inservice Training & Educatior			372	372		372		372			23
24	Travel and Seminar			1,935	1,935		1,935		1,935			24
25	Other Admin. Staff Transportatior			10,108	10,108		10,108	(2,297)	7,811			25
26	Insurance-Prop.Liab.Malpractice			51,444	51,444		51,444		51,444			26
27	Other (specify):*											27
28	**TOTAL General Administration**	131,700	29,033	303,913	464,646		464,646	(2,596)	462,050			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	1,049,825	220,718	435,760	1,706,303		1,706,303	(3,010)	1,703,293			29

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.** SEE ACCOUNTANTS' COMPILATION REPORT

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Walker Nursing Home #0021428 Report Period Beginning: 10/01/04 Ending: 09/30/05

V. COST CENTER EXPENSES (continued)

		Cost Per General Ledger				Reclass-	Reclassified	Adjust-	Adjusted	FOR OHF USE ONLY		
	Capital Expense	Salary/Wage	Supplies	Other	Total	ification	Total	ments	Total			
	D. Ownership	1	2	3	4	5	6	7**	8	9	10	
30	Depreciation			34,268	34,268		34,268	42,767	77,035			30
31	Amortization of Pre-Op. & Org											31
32	Interest											32
33	Real Estate Taxes			31,051	31,051		31,051	(411)	30,640			33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			697	697		697		697			35
36	Other (specify):*											36
37	TOTAL Ownership			66,016	66,016		66,016	42,356	108,372			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers			5,497	5,497		5,497		5,497			39
40	Barber and Beauty Shops			122	122		122		122			40
41	Coffee and Gift Shops											41
42	Provider Participation Fee			38,873	38,873		38,873		38,873			42
43	Other (specify):* Nonallowable Costs			18,656	18,656		18,656	(18,656)				43
44	TOTAL Special Cost Centers			63,148	63,148		63,148	(18,656)	44,492			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	1,049,825	220,718	564,924	1,835,467		1,835,467	20,690	1,856,157			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

****See Schedule of adjustments attached at end of cost report.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/04 Ending: 09/30/05

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.

	NON-ALLOWABLE EXPENSES	1 Amount	2 Reference	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Program				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Room				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	42,767	30		9
10	Interest and Other Investment Income				10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax	(2,222)	43		13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation	(2,297)	25		16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment	(6,570)	43		19
20	Contributions	(1,329)	43		20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainer				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotiona	(6,280)	43		25
26	Income Taxes and Illinois Persona Property Replacement Tax	(2,255)	43		26
27	CNA Training for Non-Employees				27
28	Yellow Page Advertising	(713)	21		28
29	Other-Attach Schedule **Real Estate taxes**	(411)	33		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ 20,690		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 20,690		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport		x	$		38
39						39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule		x			45
46	Other-Attach Schedule		x			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

SEE ACCOUNTANTS' COMPILATION REPORT

Walker Nursing Home

ID# 0021428

Report Period Beginning: 10/01/04

Ending: 09/30/05

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1		$		1
2				2
3				3
4				4
5				5
6				6
7				7
8				8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	Total	0		49

STATE OF ILLINOIS **Summary A**

Facility Name & ID Number Walker Nursing Home **#** 0021428 **Report Period Beginning:** 10/01/04 **Ending:** 09/30/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	A. General Services	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	0	0	0	0	0	0	0	0	0	0	0	0	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	0	0	0	0	0	0	0	0	0	0	0	0	6
7	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	7
8	**TOTAL General Services**	0	0	0	0	0	0	0	0	0	0	0	0	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	0	0	0	0	0	0	0	0	0	0	0	0	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	CNA Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	0	0	0	0	0	0	0	0	0	0	0	0	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	0	0	0	0	0	0	0	0	0	0	0	18
19	Professional Services	0	0	0	0	0	0	0	0	0	0	0	0	19
20	Fees, Subscriptions & Promotions	0	0	0	0	0	0	0	0	0	0	0	0	20
21	Clerical & General Office Expenses	(713)	0	0	0	0	0	0	0	0	0	0	(713)	21
22	Employee Benefits & Payroll Taxes	0	0	0	0	0	0	0	0	0	0	0	0	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	(2,297)	0	0	0	0	0	0	0	0	0	0	(2,297)	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(3,010)	0	0	0	0	0	0	0	0	0	0	(3,010)	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(3,010)	0	0	0	0	0	0	0	0	0	0	(3,010)	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Walker Nursing Home # 0021428 **Report Period Beginning:** 10/01/04 **Ending:** 09/30/05

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense	PAGES	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	PAGE	SUMMARY TOTALS	
	D. Ownership	5 & 5A	6	6A	6B	6C	6D	6E	6F	6G	6H	6I	(to Sch V, col.7)	
30	Depreciation	42,767	0	0	0	0	0	0	0	0	0	0	42,767	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	0	0	0	0	0	0	0	0	0	0	0	0	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	0	0	0	0	0	0	0	0	0	0	0	34
35	Rent-Equipment & Vehicles	0	0	0	0	0	0	0	0	0	0	0	0	35
36	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	36
37	**TOTAL Ownership**	42,767	0	0	0	0	0	0	0	0	0	0	42,767	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	(18,656)	0	0	0	0	0	0	0	0	0	0	(18,656)	43
44	**TOTAL Special Cost Centers**	(18,656)	0	0	0	0	0	0	0	0	0	0	(18,656)	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	21,101	0	0	0	0	0	0	0	0	0	0	21,101	45

Facility Name & ID Number Walker Nursing Hom # 0021428 Report Period Beginning: 10/01/04 Ending: 09/30/05

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
George W. White	50%	N/A		N/A		
Mary Ann White	50%	N/A		N/A		

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [X] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organizatior	6 Percent of Ownership	7 Operating Cost of Related Organizatior	8 Difference: Adjustments for Related Organizatior Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V				N/A				3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/04 Ending: 09/30/05

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week Hours	Percent	Compensation Included in Costs for this Reporting Period** Description	Amount	Schedule V. Line & Column Reference	
1	Mary Ann White	President	Co-Administrator	50.00	0	20	40.00	Salary	$ 16,800	17(1)	1
2			Office Manager			30	60.00	Salary	25,200	21(1)	2
3											3
4	George W. White	Vice-President	Co-Administrator	50.00	0	22.5	45.00	Salary	18,900	17(1)	4
5			Maintenance			27.5	55.00	Salary	23,100	6(1)	5
6											6
7	Bryan White	None	Asst. Admin	0.00	0	40	80.00	Salary	28,800	17(1)	7
8			Clerical			10	20.00	Salary	7,200	21(1)	8
9											9
10	Rachel White	None	Asst. Admin	0.00	0	40	80.00	Salary	27,840	17(1)	10
11			Clerical			10	20.00	Salary	6,960	21(1)	11
12											12
13								TOTAL	$ 154,800		13

*** If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.**

**** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.**

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/04 Ending: 09/30/05

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central offic or parent organization costs? (See instructions.) YES [ ] NO [X]

B. Show the allocation of costs below. If necessary, please attach worksheets

Name of Related Organization N/A
Street Address
City / State / Zip Code
Phone Number (
Fax Number (

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1						$	$		$	1
2										2
3										3
4				N/A						4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/04 Ending: 09/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related** YES	Related** NO	Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note Original	Amount of Note Balance	Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
	A. Directly Facility Related Long-Term											
1							$	$			$	1
2												2
3				This page not applicable								3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. **$** None **Line #** N/A

*** Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7 (See instructions.)**

SEE ACCOUNTANTS' COMPILATION REPORT

**** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)**

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/04 Ending: 09/30/05

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2004 report.		$ 17,632	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	2004	$ 27,408	2
3. Under or (over) accrual (line 2 minus line 1).		$ 9,776	3
4. Real Estate Tax accrual used for 2005 report. (Detail and explain your calculation of this accrual on the lines below.)		$ 20,864	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For Tax Year. (Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru		$ 30,640	7

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and l must accompany the cost report

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
2000	20,670	8
2001	20,511	9
2002	20,844	10
2003	23,509	11
2004	27,408	12

Accrual based on 9/12 of current real estate tax bill.

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2004	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity.**
   This denial must be no more than four years old at the time the cost report is filed

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2004 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2004 real estate tax costs, as well as copies of your original real estate tax bills for calendar 2004.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2004 real estate tax bill to the Department of Public Aid, Bureau of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2005 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Bureau of Health Finance at (217) 782-1630.

2004 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Walker Nursing Home COUNTY Cass

FACILITY IDPH LICENSE NUMBER 0021428

CONTACT PERSON REGARDING THIS REPORT Becky Hill

TELEPHONE (217) 789-7700 FAX #: (217) 753-1654

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2004 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2004.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.	09-033-009-00	Lot	$ 1,005.80	$ 1,005.80
2.	11-087-007-00	Lot	$ 22,054.42	$ 22,054.42
3.	11-052-009-00	Lot	$ 739.38	$ 739.38
4.	11-076-003-00	Lot	$ 1,873.66	$ 1,873.66
5.	11-064-010-01	Lot	$ 1,734.44	$ 1,734.44
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$ 27,407.70	$ 27,407.70

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES X NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the original 2004 tax bills which were listed in Section A to this statement. Be sure to use the 2004 tax bill which is normally paid during 2005.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/04 Ending: 09/30/05

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 23,040 B. General Construction Type: Exterior Brick Frame Wood and Steel Number of Stories 1

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization [X] (c) Rent equipment from Completely Unrelated Organization

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's groun (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, CNA training facilities, et List entity name, type of business, square footage, and number of beds/units available (where applicable

None

F. Does this cost report reflect any organization or pre-operating costs which are being amortize [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: 2. Number of Years Over Which it is Being Amortized

3. Current Period Amortization: 4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Resident care	22,176	1955	$ 11,000	1
2	Resident care	9,504	1981	23,604	2
3	TOTALS			$ 34,604	3

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Hom # 0021428 Report Period Beginning: 10/01/04 Ending: 09/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	20		1972	1972	$ 130,523	$	30	$	$	$ 130,523	4
5	30		1977	1977	363,607		30	12,120	12,120	339,361	5
6	5		1981	1981	79,226		30	2,641	2,641	65,314	6
7	16		1985	1985	399,762		30	13,326	13,326	266,517	7
8											8
	Improvement Type**										
9											9
10	Leasehold Improvements			1974	900					900	10
11	Leasehold Improvements			1975	200					200	11
12	Leasehold Improvements			1977	2,889		Various	23	23	2,844	12
13	Leasehold Improvements			1982	552		Various			552	13
14	Leasehold Improvements			1983	533		Various			533	14
15	Leasehold Improvements			1984	11,510		Various			11,510	15
16	Leasehold Improvements			1985	70,113		Various	669	669	70,048	16
17	Leasehold Improvements			1986	7,764	239	Various	204	(35)	5,625	17
18	Leasehold Improvements			1988	2,015	64	Various	66	2	1,139	18
19	Leasehold Improvements			1990	2,480		Various	41	41	2,477	19
20	Leasehold Improvements			1991	23,204	684	Various	817	133	11,015	20
21	Leasehold Improvements			1992	45,806	1,455	Various	1,508	53	20,765	21
22	Leasehold Improvements			1993	11,951	364	Various	374	10	4,551	22
23	Leasehold Improvements			1995	4,939	183	Various	278	95	4,356	23
24	Leasehold Improvements			1996	6,289		Various	613	613	5,946	24
25	Leasehold Improvements			1997	63,654	2,133	Various	2,132	(1)	17,643	25
26	Leasehold Improvements			1998	45,605	1,169	Various	1,144	(25)	8,079	26
27	Leasehold Improvements			1999	2,066	53	Various	53		342	27
28	Leasehold Improvements			2000	4,528	113	10	453	340	2,038	28
29											29
30	Detail improvements for the years 2001 - 2004										30
31	Shower Faucets			2000	1,550	39	10	155	116	698	31
32	Door Locks			2001	1,500	150	10	150		525	32
33	Water Heater			2002	4,283	107	10	426	319	1,214	33
34	New Roof			2004	28,437	711	10	711		1,066	34
35	Flooring			2005	5,323	33	39	28	(5)	28	35
36	Tiling in Showers			2005	1,062	2	39	1	(1)	1	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Walker Nursing Hom # 0021428 Report Period Beginning: 10/01/04 Ending: 09/30/05

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dolla

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 1,322,271	$ 7,499		$ 37,933	$ 30,434	$ 975,810	70

SEE ACCOUNTANTS' COMPILATION REPORT

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Numbe: Walker Nursing Hom # 0021428 Report Period Beginning: 10/01/04 Ending: 09/30/05

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instruction

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 700,518	$ 15,672	$ 26,739	$ 11,067	3-39	$ 597,461	71
72	Current Year Purchases	7,816	325	1,117	792	7	1,117	72
73	Fully Depreciated Assets							73
74								74
75	TOTALS	$ 708,334	$ 15,997	$ 27,856	$ 11,859		$ 598,578	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Resident care	Handicap Bus	2002	$ 44,983	$ 8,997	$ 11,246	$ 2,249	4	$ 39,161	76
77										77
78										78
79										79
80	TOTALS			$ 44,983	$ 8,997	$ 11,246	$ 2,249		$ 39,161	80

E. Summary of Care-Related Asset

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,110,192	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 32,493	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 77,035	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 44,542	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,613,549	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions

	1 Description & Year Acquirec	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86	1996 Dodge Ram	$ 33,608	$ 1,775	$ 33,608	86
87					87
88					88
89					89
90					90
91	TOTALS	$ 33,608	$ 1,775	$ 33,608	91

G. Construction-in-Progres

	Description	Cost	
92		$	92
93	N/A		93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column (

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/04 Ending: 09/30/05

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$ N/A			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34.
This amount was calculated by dividing the total amount to be amortized
by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2006	$
13.	/2007	$
14.	/2008	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO

16. Rental Amount for movable equipment: $ 697 Description: Maintenance equipment - 697
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18			N/A		18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Hom # 0021428 Report Period Beginning: 10/01/04 Ending: 09/30/05

XIII. EXPENSES RELATING TO CERTIFIED NURSE AIDE (CNA) TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If CNAs are trained in another facility program, attach a schedule listing the facility name, address and cost per CNA trained in that facility

1. HAVE YOU TRAINED CNAs DURING THIS REPORT PERIOD? [ ] YES [X] NO

It is the policy of this facility to only hire certified nurses aides

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - COMMUNITY COLLEGE [ ]
   - HOURS PER CNA ____

3. CLINICAL PORTION:
   - IN-HOUSE PROGRAM [ ]
   - IN OTHER FACILITY [ ]
   - HOURS PER CNA ____

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies				
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments				
8	CNA Competency Tests				
9	TOTALS	$	$	$	$
10	SUM OF line 9, col. 1 and 2 (e)	$			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training CNAs from other facilities

$

D. NUMBER OF CNAs TRAINED

COMPLETED	
1. From this facility	
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits

(b) Include wages paid during the clinical portion of training. Do not include fringe benefits

(c) For in-house training programs only. Do not include fringe benefits

(d) Allocate based on if the CNA is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own CNAs

(e) The total amount of Drop-out and Completed Costs for your own CNAs must agree with Sch. V, line 13, col. 8.

(f) Attach a schedule of the facility names and addresses of those facilities for which you trained CNAs.

SEE ACCOUNTANTS' COMPILATION REPORT

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.

		1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff Units of Service	Staff Cost	Outside Practitioner (other than consultant) Units	Outside Practitioner (other than consultant) Cost	Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy		# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify): See Sch 16A	39A(3)				5,497			5,497	13
14	TOTAL			$		$ 5,497	$		$ 5,497	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed Schedule XVIII-B. Salaries of unlicensed practitioners, such as CNAs, who help with the above activities should not be lis on this schedule.

SEE ACCOUNTANTS' COMPILATION REPORT

Walker Nursing Home
Provider #: 0021428
10/01/04 to 09/30/05 **Schedule 16A**

XIV. Special Services
Line 13 Other (specify):

Service	Line Reference	Outside Practioner Units	Cost	Supplies
Physicnan/hospital services	39(3)	Various	5,497	-

Facility Name & ID Number Walker Nursing Home **#** 0021428 **Report Period Beginning:** 10/01/04 **Ending:** 09/30/05

XV. BALANCE SHEET - Unrestricted Operating Fund. **As of** 09/30/05 **(last day of reporting year)**

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 94,598	$ 94,598	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance -0-)	177,000	177,000	3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	366,628	366,628	5
6	Prepaid Insurance			6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)	34,066	34,066	8
9	Other(specify): Employee advance	250	250	9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 672,542	$ 672,542	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments	2,024	2,024	12
13	Land	34,604	34,604	13
14	Buildings, at Historical Cost	1,030,309	1,030,309	14
15	Leasehold Improvements, at Historical Cost	291,962	291,962	15
16	Equipment, at Historical Cost	786,925	786,925	16
17	Accumulated Depreciation (book methods)	(1,787,002)	(1,647,157)	17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify): Sec. 444 election deposit	8,721	8,721	23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$ 367,543	$ 507,388	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 1,040,085	$ 1,179,930	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 6,619	$ 6,619	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	14,693	14,693	30
31	Accrued Taxes Payable (excluding real estate taxes)	157	157	31
32	Accrued Real Estate Taxes(Sch.IX-B)	20,864	20,864	32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes	4,641	4,641	35
	Other Current Liabilities(specify):			
36	Payroll related withholding	19,328	19,328	36
37	Due to Shareholder	2,000	2,000	37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 68,302	$ 68,302	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 68,302	$ 68,302	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 971,783	$ 1,111,628	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 1,040,085	$ 1,179,930	48

SEE ACCOUNTANTS' COMPILATION REPORT

***(See instructions.)**

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/04 Ending: 09/30/05

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total		
1	**Balance at Beginning of Year, as Previously Reported**	$ 953,786	1	
2	Restatements (describe):		2	
3	**Adjustments subsequent to preparation of prior year**	85	3	
4	**cost report**		4	
5			5	
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 953,871	6	
	A. Additions (deductions):			
7	NET Income (Loss) (from page 19, line 43)	134,565	7	
8	Aquisitions of Pooled Companies		8	
9	Proceeds from Sale of Stock		9	
10	Stock Options Exercised		10	
11	Contributions and Grants		11	
12	Expenditures for Specific Purposes		12	
13	Dividends Paid or Other Distributions to Owners	(116,653)	13	
14	Donated Property, Plant, and Equipment		14	
15	Other (describe)		15	
16	Other (describe)		16	
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 17,912	17	
	B. Transfers (Itemize):			
18			18	
19			19	
20			20	
21			21	
22			22	
23	**TOTAL Transfers (sum of lines 18-22)**	$	23	
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 971,783	24	*

Operating Entity Only

*** This must agree with page 17, line 47.**

SEE ACCOUNTANTS' COMPILATION REPORT

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/04 Ending: 09/30/05

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Car	$ 1,977,050	1
2	Discounts and Allowances for all Level	(19,928)	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 1,957,122	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Educatior		9
10	Other Government Grants		10
11	CNA Training Reimbursements		11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care		13
14	Non-Patient Meals		14
15	Telephone, Television and Radic		15
16	Rental of Facility Space	1,035	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patient		18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services		21
22	Laundry		22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 1,035	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income**	11,875	25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 11,875	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28			28
28a			28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 1,970,032	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	463,644	31
32	Health Care	778,013	32
33	General Administratior	464,646	33
	B. Capital Expense		
34	Ownership	66,016	34
	C. Ancillary Expense		
35	Special Cost Centers	24,275	35
36	Provider Participation Fee	38,873	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 1,835,467	40
41	**Income before Income Taxes (line 30 minus line 40)****	134,565	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 134,565	43

*** This must agree with page 4, line 45, column 4.**

**** Does this agree with taxable income (loss) per Federal Income Tax Return? No If not, please attach a reconciliation.**

***** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation. SEE ACCOUNTANTS' COMPILATION REPORT**

******Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Walker Nursing Hom # 0021428 Report Period Beginning: 10/01/04 Ending: 09/30/05

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,476	2,479	$ 58,678	$ 23.67	1
2	Assistant Director of Nursing					2
3	Registered Nurses	1,850	1,852	33,433	18.05	3
4	Licensed Practical Nurses	16,487	16,523	261,507	15.83	4
5	CNAs & Orderlies	35,061	34,976	311,307	8.90	5
6	CNA Trainees					6
7	Licensed Therapist					7
8	Rehab/Therapy Aides					8
9	Activity Director	1,768	1,772	15,770	8.90	9
10	Activity Assistants	724	725	4,837	6.67	10
11	Social Service Workers	1,916	1,920	22,080	11.50	11
12	Dietician					12
13	Food Service Supervisor					13
14	Head Cook	2,930	2,924	28,341	9.69	14
15	Cook Helpers/Assistants	10,528	10,537	78,659	7.47	15
16	Dishwashers					16
17	Maintenance Worker	2,191	2,141	31,602	14.76	17
18	Housekeepers	6,439	6,505	46,437	7.14	18
19	Laundry	2,890	2,887	25,474	8.82	19
20	Administrator	1,768	1,703	35,700	20.96	20
21	Assistant Administrator	3,328	3,328	56,640	17.02	21
22	Other Administrative					22
23	Office Manager	1,248	1,202	25,200	20.97	23
24	Clerical	832	832	14,160	17.02	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	92,436	92,306	$ 1,049,825 *	$ 11.37	34

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	120	$ 5,376	1(3)	35
36	Medical Director	20	2,000	9(3)	36
37	Medical Records Consultant				37
38	Nurse Consultant				38
39	Pharmacist Consultant				39
40	Physical Therapy Consultant	24	1,300	10A(3)	40
41	Occupational Therapy Consultan				41
42	Respiratory Therapy Consultan				42
43	Speech Therapy Consultant				43
44	Activity Consultant				44
45	Social Service Consultant	monthly	5,100	12(3)	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	164	$ 13,776		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Certified Nurse Assistants/Aides	743	14,183	10(3)	52
53	TOTAL (lines 50 - 52)	743	$ 14,183		53

SEE ACCOUNTANTS' COMPILATION REPORT

* This total must agree with page 4, column 1, line 45.

** See instructions.

Facility Name & ID Number: Walker Nursing Home # 0021428 Report Period Beginning: 10/01/04 Ending: 09/30/05

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
George W. White	Co-Adminstrator	50	$ 18,900
Mary Ann White	Co-Adminstrator	50	16,800
Bryan White	Asst. Administrator	0	28,800
Rachel White	Asst. Administrator	0	27,840
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.			$ 92,340

B. Administrative - Other

Description	Amount
	$
N/A	
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
McClure, Brannon & Thomas	Legal	$ 6,250
Enloe Pharmacy	Software consultation	150
Corporation Service	Administrative consulting	244
Robert Gordon	Administrative consulting	54
FR&R Health Care	Operations consulting	2,980
Quorum Group	Operations consulting	1,800
McGladrey & Pullen LLP	Accounting fees	19,498
Rabin, Myers & Hanken	Legal	260
Sorling, Northrup	Legal	285
Metnick, Cherry, Frazier	Legal	682
Brown, Hay & Stephens	Legal	1,999
Thompson, McNeely & Crews	Legal	744
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 34,946

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 38,442
Unemployment Compensation Insurance	12,685
FICA Taxes	79,430
Employee Health Insurance	48,023
Employee Meals	414
Illinois Municipal Retirement Fund (IMRF)*	
Other Employee Insurance	7,400
Other Employee Benefits	2,632
TOTAL (agree to Schedule V, line 22, col.8)	$ 189,026

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
N/A		
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 1,990
Advertising: Employee Recruitment	643
Health Care Worker Background Check	
(Indicate # of checks performed 35)	442
Miscellaneous Subscriptions	559
Illinois Health Care Assn dues	3,860
Miscellaneous Licenses	263
Less: Public Relations Expense	( )
Non-allowable advertising	( )
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 7,757

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	
Seminar Expense	1,935
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 1,935

* Attach copy of IMRF notifications

**See instructions.

Walker Nursing Home
Provider #: 0021428
10/01/04 to 09/30/05 **Schedule 21A**

XIX. SUPPORT SCHEDULE
C. Professional Services

Total (agree to Schedule V, line 19, column 3)	34,946
Adjustments	
Total (agree to Schedule V, line 19, column 8)	34,946

Facility Name & ID Number Walker Nursing Home # 0021428 Report Period Beginning: 10/01/04 Ending: 09/30/05

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009	FY2010
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8					N/A								
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

SEE ACCOUNTANTS' COMPILATION REPORT

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **No**

(2) Are there any dues to nursing home associations included on the cost repor **Yes**
If YES, give association name and amount **Illinois Health Care Association - 3,860**

(3) Did the nursing home make political contributions or payments to a politic action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at th end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases **Yes**
What was the average life used for new equipment added during this perioc **7 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expens and the location of this expense on Sch. V. $ **4,536** Line **10(2)**

(7) Have all costs reported on this form been determined using accounting procedur consistent with prior reports? **Yes** If NO, attach a complete explanation

(8) Are you presently operating under a sale and leaseback arrangemen **No**
If YES, give effective date of lease **N/A**

(9) Are you presently operating under a sublease agreemen ____ YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions f Schedule VII)? YES ____ NO **X** If YES, please indicate name of the facility IDPH license number of this related party and the date the present owners took ove
N/A

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Departmer during this cost report period. $ **38,873**
This amount is to be recorded on line 42 of Schedule V

(12) Are there any salary costs which have been allocated to more than one line on Schedule for an individual employee? **Yes - pg 7** If YES, attach an explanation of the allocation

SEE ACCOUNTANTS' COMPILATION REPORT

(13) Have costs for all supplies and services which are of the type that can be billed t the Department, in addition to the daily rate, been properly classifie in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services f the patient census listed on page 2, Section B? **No** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attac a schedule which explains how all related costs were allocated to these function

(15) Indicate the cost of employee meals that has been reclassified to employee benefi on Schedule V. $ **414** Has any meal income been offset agains related costs? **N/A** Indicate the amount $ **N/A**

(16) Travel and Transportation
a. Are there costs included for out-of-state travel **No**
If YES, attach a complete explanation
b. Do you have a separate contract with the Department to provide medical transportation fc residents? **No** If YES, please indicate the amount of income earned from such program during this reporting period. $ **N/A**
c. What percent of all travel expense relates to transportation of nurses and patients **100%**
d. Have vehicle usage logs been maintained **Adequate records have been maintained.**
e. Are all vehicles stored at the nursing home during the night and all oth times when not in use? **No**
f. Has the cost for commuting or other personal use of autos been adjust out of the cost report? **Yes**
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ N/A

(17) Has an audit been performed by an independent certified public accounting firm **No**
Firm Name: **N/A** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this cop been attached? **N/A** If no, please explain **N/A**

(18) Have all costs which do not relate to the provision of long term care been adjusted o out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of servic performed been attached to this cost report? **Yes**
Attach invoices and a summary of services for all architect and appraisal fee

RECONCILIATION REPORT **04:38 PM** **3/20/2006**

ITEM	Value 1	Cond.	Value 2	Difference	RESULTS	COMPARE CEL	SUB-SCHED.	LINE NO.	COL. NO.	WITH CELL	SUB-SCHED.	LINE NO.	COL. NO.
Adjustment Detail	20,690	equal to	20,690	0	O.K.	Pg5 Z22	B.	37	1	Pg4 K29	N/A	45	7
Interest Expense	0	equal to	0	0	O.K.	Pg9 P34	A.	15	10	Pg4 L13	N/A	32	8
Real Estate Tax Expenses	30,640	equal to	30,640	0	O.K.	Pg10 W24	B.	5	N/A	Pg4 L14	N/A	33	8
Amortization exp. Pre-opening & org.	0	equal to	0	0	O.K.	Pg11 I33	E.	3	N/A	Pg4 L12	N/A	31	8
Ownership Costs-Depreciation	77,035	equal to	77,035	0	O.K.	Pg13 Y28	E.	49	2	Pg4 L11	N/A	30	8
Rental Costs A	0	equal to	0	0	O.K.	Pg14 L20+N22	A.	7 + 8	4+N/A	Pg4 L15	N/A	34	8
Rental Costs B	697	equal to	697	0	O.K.	Pg14 J30+N40	B.+ C.	16+21	N/A+4	Pg4 L16	N/A	35	8
Nurse Aid Training Prog.	0	equal to	0	0	O.K.	Pg15 L36	B.	10	1	Pg3 L23	N/A	13	8
Special Serv.- Staff Wages		equal to		0	O.K.	Pg16 N32	N/A	14	3	Pg4 E22	N/A	39	1
Therapy Services	1,300	equal to	1,300	0	O.K.	Pg16 Z12+Z14.	N/A;B	1-4;40-43	8;2	Pg3 H20	N/A	1Oa	4
Special Serv.- Supplies		equal to	0	#VALUE!	#VALUE!	Pg16 V32	N/A	14	6	Pg4 F22 + Pg 3	N/A	39,10a	2
Income Stat. General Serv.	463,644	equal to	463,644	0	O.K.	Pg19 P11	N/A	31	2	Pg3 H16	N/A	8	4
Income Stat. Health Care	778,013	equal to	778,013	0	O.K.	Pg19 P12	N/A	32	2	Pg3 H26	N/A	16	4
Income Stat. Admininstation	464,646	equal to	464,646	0	O.K.	Pg19 P13	N/A	33	2	Pg3 H39	N/A	28	4
Income Stat. Ownership	66,016	equal to	66,016	0	O.K.	Pg19 P15	N/A	34	2	Pg4 H18	N/A	37	4
Income Stat. Special Cost Ctr	24,275	equal to	24,275	0	O.K.	Pg19 P17	N/A	35	2	Pg4 H21..H24+I	N/A	38to41+43	4
Income Stat. Prov. Partic.	38,873	equal to	38,873	0	O.K.	Pg19 P18	N/A	36	2	Pg4 H25	N/A	42	4
Staff- Nursing	664,925	equal to	664,925	0	O.K.	Pg20 K11..K15+	A.	1-5,24,25,27-30	3	Pg3 E19	N/A	10	1
Staff- Nurse aide Training	0	< or = to		0	O.K.	Pg20 K16	A.	6	3	Pg3 E23	N/A	13	1
Staff-Licensed Therapist	0	equal to		0	O.K.	Pg20 K17	A.	7	3	Pg4 E22	N/A	39	1
Staff- Activities	20,607	equal to	20,607	0	O.K.	Pg20 K19+K20	A.	9+10	3	Pg3 E21	N/A	11	1
Staff- Social Serv. Workers	22,080	equal to	22,080	0	O.K.	Pg20 K21	A.	11	3	Pg3 E22	N/A	12	1
Staff- Dietary	107,000	equal to	107,000	0	O.K.	Pg20 K22..K26	A.	16-Dec	3	Pg3 E9	N/A	1	1
Staff- Maintenance	31,602	equal to	31,602	0	O.K.	Pg20 K27	A.	17	3	Pg3 E14	N/A	6	1
Staff- Housekeeping	46,437	equal to	46,437	0	O.K.	Pg20 K28	A.	18	3	Pg3 E11	N/A	3	1
Staff- Laundry	25,474	equal to	25,474	0	O.K.	Pg20 K29	A.	19	3	Pg3 E12	N/A	4	1
Staff- Administrative	92,340	equal to	92,340	0	O.K.	Pg20 K30..K32	A.	20-22	3	Pg3 E28	N/A	17	1
Staff- Clerical	39,360	equal to	39,360	0	O.K.	Pg20 K33..K34	A.	23+24	3	Pg3 E32	N/A	21	1
Staff- Medical Director	0	equal to		0	O.K.	Pg20 K37	A.	27	3	Pg3 E18	N/A	9	1
Total Salaries And Wages	1,049,825	equal to	1,049,825	0	O.K.	Pg20 K44	A.	34	3	Pg4 E29	N/A	45	1
Dietary Consultant	5,376	< or = to	5,376	0	O.K.	Pg20 X12	B.	35	2	Pg3 G9	N/A	1	3
Medical Director	2,000	< or = to	2,000	0	O.K.	Pg20 X13	B.	36	2	Pg3 G18	N/A	9	3
Consultants & contractors	14,183	< or = to	14,183	0	O.K.	Pg20 X14..X16+	B. & C.	37to39 and 50to5	2	Pg3 G19	N/A	10	3
Activity Consultant	0	< or = to		0	O.K.	Pg20 X21	B.	44	2	Pg3 G21	N/A	11	3
Social Service Consultant	5,100	< or = to	5,100	0	O.K.	Pg20 X22	B.	45	2	Pg3 G22	N/A	12	3
Supp. Sched.- Admin. Salar.	92,340	equal to	92,340	0	O.K.	Pg21 I16	A.	N/A	N/A	Pg3 E28	N/A	17	1
Supp. Sched.- Admin. Other		equal to		0	O.K.	Pg21 I24	B.	N/A	N/A	Pg3 G28	N/A	17	3
Supp. Sched.- Prof. Serv.	34,946	equal to	34,946	0	O.K.	Pg21 I41	C.	N/A	N/A	Pg3 G30	N/A	19	3
Supp. Sched.- Benefit/Taxes	189,026	equal to	189,026	0	O.K.	Pg21 P22	D.	N/A	N/A	Pg3 L33	N/A	22	8
Supp. Sched.- Sched of dues..	7,757	equal to	7,757	0	O.K.	Pg21 V22	F.	N/A	N/A	Pg3 L31	N/A	20	8
Supp. Sched.- Sched. of trav	1,935	equal to	1,935	0	O.K.	Pg21 V41	G.	N/A	N/A	Pg3 L35	N/A	24	8
Gen. Info - Particip. Fees	38,873	equal to	38,873	0	O.K.	Pg23 I38	N/A	11	N/A	Pg4 G25	N/A	42	3
Gen. Info - Employee Meals	414	< or = to	414	0	O.K.	Pg23 S16	N/A	16	N/A	Pg3 K33	N/A	2 & 22	7
Gen. Info - Employee Meals	414	equal to	414	0	O.K.	Pg23 S16	N/A	16	N/A	Pg21 P12	D.	N/A	N/A
Nurse aide training	0	equal to		0	O.K.	Pg15 U29..U31	B.	3, 4 & 5	4	Pg3 E23	N/A	13	1
Days of medicare provided	N/A	equal to	0	#VALUE!	#VALUE!	Pg2 AB29	K.	N/A	N/A	Pg2 J30	B.	8	4
Adjustment for related org. costs		equal to	0	#VALUE!	#VALUE!	Pg5 Z18	B.	34	1	Pg6 to Pg 6I Y4	B.	14	8
Total loan balance	0	equal to	0	0	O.K.	Pg9 L34	A.	15	7	Pg17 V13+V27.	N/A	29+39-41	2
Real estate tax accrual	20,864	equal to	20,864	0	O.K.	Pg10 W15	B.	4	N/A	Pg17 V17	N/A	32	2
Land	34,604	equal to	34,604	0	O.K.	Pg11 T43	A.	3	4	Pg17 K25	N/A	13	2
Building cost	1,322,271	equal to	1,322,271	0	O.K.	Pg12 to 12I L43	B.	36	4	Pg17 K26+K27	N/A	14 & 15	2
Equipment and vehicle cost	753,317	equal to	786,925	-33,608	FAILED	Pg13 O22+L13	C.& D.	41 + 46	1 + 4	Pg17 K28	N/A	16	2
Accumulated depr.	1,613,549	equal to	1,647,157	-33,608	FAILED	Pg13 Y30	E.	51	2	Pg17 K29	N/A	17	2
End of year equity	971,783	equal to	971,783	0	O.K.	Pg18 I33	N/A	24	1	Pg17 S39	N/A	47	1
Net income (loss)	134,565	equal to	134,565	0	O.K.	Pg18 I15	N/A	7	1	Pg19 P30	N/A	43	2
Unamortized deferred maint. cost	0	equal to		0	O.K.	Pg22 F31-J31..S	H.	20	3	Pg17 K30	N/A	18	2
Balance Sheet	1,040,085	equal to	1,040,085	0	O.K.	Pg17:H41		25	1	Pg17 S41	N/A	48	1

	Salaries	Supplies	Other	Total	Reclass-ifications	Reclassified Total	Adjustments	Adjusted Total
1. Dietary	107,000	1,745	5,376	114,121	0	114,121	0	114,121
2. Food Purchase	0	123,119	0	123,119	0	123,119	(414)	122,705
3. Housekeeping	46,437	10,534	0	56,971	0	56,971	0	56,971
4. Laundry	25,474	41	1,317	26,832	0	26,832	0	26,832
5. Heat and Other Utilities	0	0	62,786	62,786	0	62,786	0	62,786
6. Maintenance	31,602	9,806	38,407	79,815	0	79,815	0	79,815
7. Other (specify)*	0	0	0	0	0	0	0	0
8. Total General Services	210,513	145,245	107,886	463,644	0	463,644	(414)	463,230
9. Medical Director	0	0	2,000	2,000	0	2,000	0	2,000
10. Nursing & Medical Records	664,925	41,928	14,183	721,036	0	721,036	0	721,036
10a. Therapy	0	0	1,300	1,300	0	1,300	0	1,300
11. Activities	20,607	4,512	0	25,119	0	25,119	0	25,119
12. Social Services	22,080	0	5,100	27,180	0	27,180	0	27,180
13. Nurse Aide Training	0	0	0	0	0	0	0	0
14. Program Transportation	0	0	1,378	1,378	0	1,378	0	1,378
15. Other (specify)*	0	0	0	0	0	0	0	0
16. Total Health Care & Programs	707,612	46,440	23,961	778,013	0	778,013	0	778,013
17. Administrative	92,340	0	0	92,340	0	92,340	0	92,340
18. Directors Fees	0	0	0	0	0	0	0	0
19. Professional Services	0	0	34,946	34,946	0	34,946	0	34,946
20. Fees, Subscriptions & Promotion	0	0	7,757	7,757	0	7,757	0	7,757
21. Clerical & General Office	39,360	29,033	8,739	77,132	0	77,132	(713)	76,419
22. Employee Benefits & Payroll	0	0	188,612	188,612	0	188,612	414	189,026
23. Inservice Training & Education	0	0	372	372	0	372	0	372
24. Travel and Seminar	0	0	1,935	1,935	0	1,935	0	1,935
25. Other Admin. Staff Trans	0	0	10,108	10,108	0	10,108	(2,297)	7,811
26. Insurance-Prop.Liab.Malpractice	0	0	51,444	51,444	0	51,444	0	51,444
27. Other (specify)*	0	0	0	0	0	0	0	0
28. Total General Adminis	131,700	29,033	303,913	464,646	0	464,646	(2,596)	462,050
29. Total General Administrative	1,049,825	220,718	435,760	1,706,303	0	1,706,303	(3,010)	1,703,293
30. Depreciation	0	0	34,268	34,268	0	34,268	42,767	77,035
31. Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0
32. Interest	0	0	0	0	0	0	0	0
33. Real Estate	0	0	31,051	31,051	0	31,051	(411)	30,640
34. Rent - Facility & Grounds	0	0	0	0	0	0	0	0
35. Rent - Equipment & Vehicles	0	0	697	697	0	697	0	697
36. Other (specify):*	0	0	0	0	0	0	0	0
37. Total Ownership	0	0	66,016	66,016	0	66,016	42,356	108,372
38. Medically Necessary T	0	0	0	0	0	0	0	0
39. Ancillary Service Cent	0	0	5,497	5,497	0	5,497	0	5,497
40. Barber and Beauty Shop	0	0	122	122	0	122	0	122
41. Coffee and Gift Shops	0	0	0	0	0	0	0	0
42	0	0	38,873	38,873	0	38,873	0	38,873
43. Other (specify):*	0	0	18,656	18,656	0	18,656	(18,656)	0
44. Total Special Cost Ce	0	0	63,148	63,148	0	63,148	(18,656)	44,492
45. Grand Total	1,049,825	220,718	564,924	1,835,467	0	1,835,467	20,690	1,856,157

	Operating	After Consolidation
General Service Cost Center		
1. Cash on hand and in banks	94,598	94,598
2. Cash - Patient Deposits	0	0
3. Accounts & Notes Recievable	177,000	177,000
4. Supply Inventory	0	0
5. Short-Term Investments	366,628	366,628
6. Prepaid Insurance	0	0
7. Other Prepaid Expenses	0	0
8. Accounts Receivable-Owner/Related Party	34,066	34,066
9. Other (specify):	250	250
10. Total current assets	672,542	672,542
LONG TERM ASSETS		
11. Long-Term Notes Receivable	0	0
12. Long-Term Investments	2,024	2,024
13. Land	34,604	34,604
14. Buildings, at Historical Cost	1,030,309	1,030,309
15. Leasehold Improvements, Historical Cost	291,962	291,962
16. Equipment, at Historical Cost	786,925	786,925
17. Accumulated Depreciation (book methods)	########	-1,647,157
18. Deferred Charges	0	0
19. Organization & Pre-Operating Costs	0	0
20. Accum Amort - Org/Pre-Op Costs	0	0
21. Restricted Funds	0	0
22. Other Long-Term Assets (specify):	0	0
23. other (specify):	8,721	8,721
24. Total Long-Term Assets	367,543	507,388
25. Total Assets	1,040,085	1,179,930
CURRENT LIABILITIES		
26. Accounts Payable	6,619	6,619
27. Officer's Accounts Payable	0	0
28. Accounts Payable-Patients Deposits	0	0
29. Short-Term Notes Payable	0	0
30. Accrued Salaries Payable	14,693	14,693
31. Accrued Taxes Payable	157	157
32. Accrued Real Estate Taxes	20,864	20,864
33. Accrued Interest Payable	0	0
34. Deferred Compensation	0	0
35. Federal and State Income Taxes	4,641	4,641
36. Other Current Liabilities (specify):	19,328	19,328
37. Other Current Liabilities (specify):	2,000	2,000
38. Total Current Liabilities	68,302	68,302
LONG TERM LIABILITES		
39.Long-Term Notes Payable	0	0
40.Mortgage Payable	0	0
41.Bonds Payable	0	0
42.Deferred Compensation	0	0
43.Other Long-Term Liabilities (specify):	0	0
44.Other Long-Term Liabilities (specify):	0	0
45.Total Long-Term Liabilities	0	0
46.Total Liabilities	68,302	68,302
47.Total Equity	971,783	1,111,628
48.Total Liabilities and Equity	1,040,085	1,179,930

	Balance per Medicaid Trial Balance
1. Gross Revenue - All levels of Care	1,977,050
2. Discounts and Allowances for all Levels	-19,928
Subtotal - Inpatient Care	1,957,122
4. Day Care	0
5. Other Care for Outpatients	0
6. Therapy	0
7. Oxygen	0
Subtotal - Anciliary Revenue	-
9. Payments for Education	0
10. Other Governmental Grants	0
11. Nurses Aide Training Reimbursements	0
12. Gift and Coffee Shop	0
13. Barber and Beauty Care	0
14. Non-Patient Meals	0
15. Telephone, Television, and Radio	0
16. Rental of Facility Space	1,035
17. Sale of Drugs	0
18. Sale of Supplies to Non-Patients	0
19. Laboratory	0
20. Radiologyand X-Ray	0
21. Other Medical Services	0
22. Laundry	0
Subtotal - Other Operating Revenue	1,035
24. Contributions	0
25. Interest and Other Investments Income	11,875
Subtotal - Non-Operating Revenue	11,875
27. Other Revenue (specify):	0
28. Other Revenue (specify):	0
Subtotal - Other Revenue	-
30. Total Revenue	1,970,032
31. General Services	463,644
32. Health Care	778,013
33. General Administration	464,646
34. Ownership	66,016
35. Special Cost Centers	24,275
35. Provider Participation Fee	38,873
37. Other	0
40. Total Expenses	1,835,467
41. Income Before Income Taxes	134,565
42. Income Taxes	0
43. Net Income or Loss for the Year	134,565